Navy Medical Accessions Department

Annual Health Screening Form for HPSP, NCP, FAP and NADDS Participants

Medical Questionnaire: Submit appropriate documentation for all "YES" answers.

1. Personal Inform	ation					
Name:		Rank:		Phone:		
E-Mail:	E-Mail:		N:	Grad Year:		
Program: HPSP:	1975 (Medical Corps)	1985 (Dental Co	rps)	1995 (Medical Sei	rvice Corps)	
	FAP	NADDS	NCP			
2. Have you had any injury absent from school or trail If yes, explain:	r, illness or disease within the phing?	past 12 months whi	ch required	d hospitalization o	r caused you YES	to be NO
3. Are you now, or have you	ou been in the care of a Health	Professional during	g the past 1	.2 months?	YES	NO
4. Have you been prescribed or taken any prescription medications in the past 12 months? If yes, please list PRESCRIBED medications and reasons for their use:						NO
5. Do you have any physica from coming on active dut If yes, explain:	al or psychological concerns w y?	hich might restrict y	our perfor	mance on active d	uty or prever	n t you NO
. Date of your last HIV test: 7. Date of MEPS Physical Exam:						
HIV testing is required e	very two years. Please submit p	proof of testing and	results if a	new test was requ	ired.	
8. Current Height in Inches	s: Current Weight ir	Pounds:	Age:	Sex:		
I certify that the information	on contained in this form is tru	ue and complete to	the best of	my knowledge. I i	understand t	hat I
	dditional documentation for a			,		
Member's Signature:		Date:				
Provider's Signature:		Date:				

PRIVACY ACT STATEMENT: Authority 44 USC 3101 and EQ 9397. Principal Purpose: College information. The SSN is used to positively identify student. Routine Use: Information used to manage HPSP/FAP/NCP/NADDS program students. Disclosure: Voluntary, however, failure to supply this information could result in suspension/termination of benefits (LWOP or separation).

Current Mailing address: (Where you receive your personal mail)

Primary Phone #: Secondary Cell Home

Phone #: Cell Home

Email that you use everyday-